SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Filing at a Glance

Company: Wesco Insurance Company

Product Name: Stop Loss	SERFF Tr Num: UNKP-127390241	State: Arkansas
TOI: H12 Health - Excess/Stop Loss	SERFF Status: Closed-Approved-Closed	State Tr Num: 49692
Sub-TOI: H12.001 Accident & Sickness	Co Tr Num: AH990004	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: Susan Coulter	Disposition Date: 09/08/2011
	Date Submitted: 08/31/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Stop Loss Filing	Status of Filing in Domicile: Pending
Project Number: AH990004	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 09/08/2011	
State Status Changed: 09/08/2011	Deemer Date:
Created By: Susan Coulter	Submitted By: Susan Coulter

Corresponding Filing Tracking Number:

Filing Description:

Wesco Insurance Company is filing the attached stop loss forms for your review and approval. These forms will be used with large and small employer groups in your state. The employer application, Form WIC-AHSL-APP will be completed by the employer and will become the schedule of benefits upon acceptance by the carrier. It will be attached to the policy as part of its entire contract provision. The program is issued for the benefit of employers and issued for an annual term. Employees do not derive benefits from nor are they a party to the insurance contract.

The minimum attachment points will be no less than $20,000 specific attachment point and has an annual aggregate attachment point, for groups of 50 or fewer, that is no lower than the greater of:

(i) $4,000 times the number of group members;
(ii) 120 percent of expected claims; or
(iii) $20,000

Has an annual aggregate attachment point for groups of 51 or more that is no lower than 110 percent of expected claims.

The minimum number of lives for an eligible employer group will be 10, unless your state requires a larger minimum number. The carrier will comply with those minimum requirements.

The Endorsements provide a variety of funding options for the employer to select.

The rates will be based on the Tillinghast (Tower Watson) Rate manuals for specific and aggregate products. This rate manual was approved in your state. To protect the proprietary nature of the program due its licensing restrictions, we are filing the cover page and table of contents only. If you need the entire manual, we will attach it.

These are new forms for Wesco Insurance Company and will not supersede any form on file with the department.

Company and Contact

Filing Contact Information

Susan Coulter,
379 Princeton-Hightstown Road, Suite 15
Cranbury, NJ 08512

susan@coulter-and-associates.com
609-443-4140 [Phone]

Filing Company Information

Wesco Insurance Company
59 Maiden Ln, 6th Fl

New York, NY 10038

(212) 220-7120 ext. [Phone]

CoCode: 25011
Group Code: 2538

Group Name: AmTrust Financial Group
FEIN Number: 85-0165753

State of Domicile: Delaware
Company Type: Property & Casualty
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$500.00
Retaliatory?	Yes

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Fee Explanation: AR and DE both impose $50 per form/rate so same

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Wesco Insurance Company	$500.00	08/31/2011	51128397

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/08/2011	09/08/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	09/07/2011	09/07/2011	Susan Coulter	09/08/2011	09/08/2011

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Disposition

Disposition Date: 09/08/2011
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Wesco Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	authorization to file	Approved-Closed	Yes
Form	Excess Stop-Loss Insurance Policy	Approved-Closed	Yes
Form	Advanced Funding Endorsement	Approved-Closed	Yes
Form	Aggregate Excess Loss Terminal Liability Endorsement	Approved-Closed	Yes
Form	Aggregating Specific Liability Endorsement	Approved-Closed	Yes
Form	Monthly Cummulative Accomodation for Aggregate Excess Loss Endorsement	Approved-Closed	Yes
Form	Family Specific Attachment Point Endorsement	Approved-Closed	Yes
Form	Specific Excess Loss Termination Liability Endorsement	Approved-Closed	Yes
Form	Disclosure Form	Approved-Closed	Yes
Form *(revised)*	Application and Schedule of Excess Stop-Loss Insurance	Approved-Closed	Yes
Form	Application and Schedule of Excess Stop-Loss Insurance	Replaced	Yes
Rate	rate manual cover	Approved-Closed	Yes
Rate	rate manual cover	Approved-Closed	Yes

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/07/2011
Submitted Date	09/07/2011
Respond By Date	

Dear Susan Coulter,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application and Schedule of Excess Stop-Loss Insurance, WIC-AHSL-APP (Form)

Comment:

The application must contain the NOTICE as outlined under our Bulletin 6-2008.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/08/2011
Submitted Date	09/08/2011

Dear Rosalind Minor,

Comments:
Thank you for your feedback.

Response 1

Comments: I have revised the application for Arkansas to include the notice as is required under Bulletin 6-2008.

Related Objection 1

Applies To:

- Application and Schedule of Excess Stop-Loss Insurance, WIC-AHSL-APP (Form)

Comment:

The application must contain the NOTICE as outlined under our Bulletin 6-2008.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application and Schedule of Excess Stop-Loss Insurance	WIC-AHSL-APP-AR		Schedule Pages	Initial		56.200	WIC-AHSL-APP-AR.pdf
Previous Version							
Application and Schedule of Excess	*WIC-AHSL-*		*Schedule Pages*	*Initial*		*56.200*	WIC-AHSL-

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Stop-Loss Insurance *APP* APP 0811.pdf

No Rate/Rule Schedule items changed.

If you have any questions, please feel free to email me at dana@coulter-and-associates.com or call (609) 443-7540. Thank you.

Sincerely,
Susan Coulter

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/08/2011	AH990004	Policy/Contract/Fraternal Certificate	Excess Stop-Loss Insurance Policy	Initial		55.600	AH990004 0811 Stop Loss Policy.pdf
Approved-Closed 09/08/2011	AH990005	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Advanced Funding Endorsement	Initial		50.800	AH990005 0811 Advanced Funding Rider.pdf
Approved-Closed 09/08/2011	AH990006	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregate Excess Loss Terminal Liability Endorsement	Initial		48.000	AH990006 0811 Aggregate Terminal Liability Rider.pdf
Approved-Closed 09/08/2011	AH990007	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregating Specific Liability Endorsement	Initial		42.500	AH990007 0811 Aggregating Specific Liability Fund Rider.pdf

SERFF Tracking Number:	*UNKP-127390241*		*State:*	*Arkansas*		
Filing Company:	*Wesco Insurance Company*		*State Tracking Number:*	*49692*		
Company Tracking Number:	*AH990004*					
TOI:	*H12 Health - Excess/Stop Loss*		*Sub-TOI:*	*H12.001 Accident & Sickness*		
Product Name:	*Stop Loss*					
Project Name/Number:	*Stop Loss Filing/AH990004*					
Approved-Closed 09/08/2011	AH990008	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Monthly Cummulative Accomodation for Aggregate Excess Loss Endorsement	Initial	51.200	AH990008 0811 Monthly Cumulative Accommodation Rider.pdf
Approved-Closed 09/08/2011	AH990009	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Family Specific Attachment Point Endorsement	Initial	57.200	AH990009 0811 Specific Excess Loss Family Deductible Rider.pdf
Approved-Closed 09/08/2011	AH990010	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Specific Excess Loss Termination Liability Endorsement	Initial	46.800	AH990010 0811 Specific Loss Termination Liability Rider.pdf
Approved-Closed 09/08/2011	SL-DISCLOSURE	Other	Disclosure Form	Initial		SL-DISCLOSURE 0811 Disclosure Form.pdf
Approved-Closed 09/08/2011	WIC-AHSL-APP-AR	Schedule Pages	Application and Schedule of Excess Stop-Loss Insurance	Initial	56.200	WIC-AHSL-APP-AR.pdf

Underwritten by Wesco Insurance Company
5800 Lombardo Center, Suite 200
Cleveland, OH 44131

EXCESS STOP - LOSS INSURANCE POLICY

Non – Participating

PLEASE READ CAREFULLY

This **Policy** is issued in consideration of **Your Application** and the payment of premiums. The attached **Application** and a copy of **Your** Employee Welfare Benefit **Plan** or **Your** PPO/HMO member booklet/certificate on file with **Us** form a part of this Policy.

All periods of coverage will begin and end at 12:01a.m. Standard Time at **Your** Principal Address.

This **Policy** is governed by the laws of the state of **Your** Principal Address except to the extent which is pre-empted by ERISA.

This **Policy** is issued by **Us** or **Our** Underwriting Offices as of the Effective Date.

In witness whereof Wesco Insurance Company has caused this **Policy** to be signed by its President and Secretary.

President

Secretary

TABLE OF CONTENTS

APPLICATION/SCHEDULE ATTACHED AT ISSUE

SECTION I.
DEFINITIONS

Actively at Work The definition used in the **Plan** or the PPO/HMO member booklet/certificate will apply under this Policy.

Aggregate Reimbursement Percentage means the percentage at which payment for **Covered Services** under **Your Plan**, in excess of **Your** Annual Aggregate Attachment Point, will be reimbursed by **Us**.

Aggregating Specific Deductible means the amount retained and **Paid** by **You** during the **Policy Period** for **Plan Benefits**, which are in excess of the **Specific Attachment Point**, equal to **Plan Benefits** in excess of the **Specific Attachment Point** multiplied by the **Specific Reimbursement Percentage**

Annual Aggregate Attachment Point means, for the **Policy Period** or any portion of the **Policy Period**, the **Plan Benefits** covered by this **Policy** and wholly retained by **You**. It is not considered for reimbursement under this Policy, and is the greater of:

1. the sum of **Monthly Aggregate Factor** amounts for each month of the **Policy Period**, determined by multiplying the total number of **Covered Units** by the **Monthly Aggregate Factor** amounts; or
2. the Minimum **Annual Aggregate Attachment Point** shown in the **Schedule**.

The maximum per **Covered Person** which may be applied annually to the Annual Aggregate Attachment Point, (i.e. **Individual Claim Limit**) is shown in the **Schedule**.

Application means that Excess Stop- Loss Insurance **Application** signed by **You** and attached to this Policy. The **Application** is subject to acceptance by **Us** and, if accepted, will become a part of this Policy.

Benefit Period means the period of time during which Covered Expenses must be **Incurred** by a **Covered Person** and **Paid** by **You** to be eligible for reimbursement under this Policy.

COBRA Continuee means a **Covered Unit** that elects to extend its group health coverage under the **Plan** as entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Company (**We**, **Us**, **Our**) means Wesco Insurance Company.

Covered Person means an enrolled employee and/or his/her eligible dependents covered under the respective **Plan** (PPO/HMO) administered by TPA. Under the **Plan** (HMO), **Covered Person** may be referred to as the Member.

Covered Services means a service or supply specified in the **Plan** for which benefits will be provided by the **TPA**.

Covered Unit means an employee, and employee with dependents, or such other defined unit as agreed upon between **You** and **Us**, as shown in the **Application**.

Endorsement means a written amendment or addendum that alters the terms of this Policy.

Experimental or Investigational The definition used in the **Plan** or the PPO/HMO member booklet/certificate will apply under this Policy.

Incurred means with respect to medical services or supplies, the date on which the **Covered Services** are rendered or supplies are received by the **Covered Person** or the Member.

Individual Claim Limit means the maximum amount of Payments for **Covered Services** that will be counted for any one **Covered Person** under Aggregate Excess Loss. The **Individual Claim Limit** is shown in the **Schedule**.

Late Entrant means a **Covered Person** whose coverage under the **Plan** was initiated at any time other than during an authorized enrollment period as allowed under the **Plan**.

Large Claim (LC) means **Paid** or pending claims reaching, or with the potential to reach, 50% of the **Specific Attachment Point** or PCL.

Minimum Annual Aggregate Attachment Point means the amount of total Payments **You** must make under **Your Plan** before **You** are eligible for reimbursement under Aggregate Excess Loss coverage. The **Minimum Annual Aggregate Attachment Point** is shown in the **Schedule**.

Monthly Aggregate Factor means the factor(s) which is/are multiplied by the number of **Covered Units** for each **Policy Month** to determine the Annual Aggregate Attachment Point. The **Monthly Aggregate Factor**(s) is/are shown in the **Schedule**.

Paid (Payment) means that a claim has been adjudicated by the **TPA** and the funds are actually disbursed by the **Plan** prior to the end of the **Benefit Period**. Payment of a claim is the unconditional and

direct payment of a claim to a **Covered Person** or his or her health care provider(s). Payment will be deemed made on the date that both:

1. the payor directly tenders payment by mailing (or by other form of delivery) a draft or check; and
2. the account upon which the payment is drawn contains, and continues to contain, sufficient funds to permit the check or draft to be honored by the institution upon which is drawn.

Plan (Employee Welfare Benefit Plan prepared by the Plan Sponsor or PPO/HMO group benefit contract issued by the **TPA**) means the self-insured health benefit program **You** have agreed to make available to **Your** employees and their eligible dependents which is administered by the **TPA**.

Plan Benefits means expenses for **Covered Services** for health benefits covered by the **Plan** during the **Policy Period** which are [**Incurred** and **Paid**] [**Paid**] by **TPA** during the **Policy Period**.

Plan Benefits will also include those health benefits covered by the **Plan** during the **Policy Period** which are **Paid** during any **Run-Out Period** or **Incurred** during any **Run-In Period** applicable to this Policy.

Plan Benefits do not include:

1. deductibles of the **Plan**:
2. co-insurance or co-payment amounts of the **Plan**:
3. services that are not covered by the **Plan** or this **Policy**:
4. amounts recovered by TPA from a third party under subrogation or
5. amounts **Paid** under a previous policy or arrangement or excess stop - loss coverage, whether issued by **Us** or another entity.

Plan Document means the written instrument which describes the **Plan** and names the fiduciaries or trustees who jointly and separately have authority to control and manage the operations and administration of the **Plan**. The **Plan Document** must be in effect on the Effective Date of this Policy. The **Plan Document** may be attached to and made a part of this Policy. Any changes to the **Plan Document** must be approved by **Us**. (See the "Changes to **Your Plan** provision.)

Policy means this Excess Stop - Loss Insurance Policy issued by **Us** to **You**.

Policy Month means, for the first **Policy Month**, the period beginning on the Effective Date of this **Policy** and ending on the corresponding date of the following month. Subsequent **Policy Month**s begin on the corresponding date of each calendar month and continue until the corresponding date of the next month to the Policy Expiration Date.

Policy Period means the time period beginning on the Effective Date and ending on the Expiration Date.

Policyholder (Plan Sponsor, **You** or **Your**) means the Plan Sponsor, named on the face page, to whom this **Policy**'s issued.

Potentially Catastrophic Loss (PCL) means a **Paid** or pending claim that has the potential to be catastrophic. **PCL's** include, but are not limited to the conditions listed in Exhibit I.

Premium Due Date is the first day of each calendar month. If the Effective Date of this **Policy** is other than the first day of a calendar month, the first month's premium will be pro-rated.

Run-In–Limit means the maximum benefit amount **Paid** by **You** under **Your Plan** for Eligible Expenses **Incurred** by a **Covered Person** during the **Run-In-Period** which will be applied toward payment under this Policy.

Run-In-Period means the period of time shown in the **Schedule** immediately prior to the first day of a **Policy Period** during which **Covered Services** Incurred by a **Covered Person** or Member, which are **Paid** by **You** during the **Policy Period**, will be considered when determining benefit payments under this Policy.

Run-Out-Period means the period of time shown in the **Schedule** immediately following this Policy's Expiration Date during which **Plan Benefits Paid** by **You** for **Covered Services Incurred** by a **Covered Person** during the **Policy Period** will be considered when determining benefit payments under this Policy.

Schedule means the completed application that is also the Schedule of Excess Stop - Loss Insurance.

Specific Attachment Point means the amount which is retained and **Paid** by **You** during the **Policy Period** and is not eligible for coverage or reimbursement under this Policy. It is not considered for reimbursement under this Policy. The **Specific Attachment Point** applies separately to each **Covered Person** on a per illness basis. The **Specific Attachment Point** is shown in the **Schedule**.

Specific Lifetime Maximum Reimbursement means the maximum amount **We** will reimburse **You** with respect to any **Covered Person** under this and prior or later Policies issued by **Us**. The Lifetime

Maximum excludes the **Specific Attachment Point** amount. The Lifetime Maximum will not exceed the lessor of:

1. the amount shown in the **Schedule**; or
2. the lifetime amount set forth in the **Plan**.

Specific Reimbursement Percentage means the percentage at which Eligible Expenses, in excess of **Your Specific Attachment Point**, will be reimbursed by **Us**.

Third Party Administrator (**TPA**) means a company having a written agreement with **You** to process **Plan Benefits** and provide administrative services. The **TPA** for your **Plan** is shown on Page 1 of this Policy.

The term **Third Party Administrator**, as used in this Policy, does not refer to the Plan Administrator or Plan Sponsor used in the Employee Retirement Income Security Act (ERISA) of 1974, as amended, unless **You** have specifically appointed the **Third Party Administrator** as such.

SECTION II.
SPECIFIC EXCESS STOP - LOSS COVERAGE

We will reimburse **You** for **Plan Benefits Paid** in excess of the **Specific Attachment Point**, not to exceed the Specific Benefit Limit shown in the **Schedule**.

We will reimburse **You** after **You** have provided proof of **Paid Plan Benefits** to the **TPA**

The Specific Excess Loss benefit applies to a **Policy Period** or fraction thereof (due to termination). As determined with regard to each **Covered Person**, it is the lesser of:

1. the Specific Lifetime Maximum; or
2. eligible **Plan Benefit** Payments made with regard to a **Covered Person**, less the **Specific Attachment Point**, the result of which is then multiplied by the **Specific Reimbursement Percentage**.

In addition, the Specific Excess Loss Benefits Payable under this **Policy** will be reduced by the **Aggregating Specific Deductible**.

If, for any reason, **Your** Specific Excess Loss coverage terminates before the end of the **Policy Period**:

1. all coverages under this **Policy** will end immediately;
2. the **Run-Out Period**, if any, will not apply; and
3. the **Specific Attachment Point** shown in the **Schedule** will continue to apply and it will not be reduced.

SECTION III.
AGGREGATE EXCESS STOP - LOSS COVERAGE

The Aggregate Excess Loss benefit for the **Policy Period**, or fraction thereof (due to termination), is the **Plan Benefit** Payments made for **Covered Services** during the **Policy Period** less;

1. the greater of the Minimum **Annual Aggregate Attachment Point** or the calculated Annual Aggregate Attachment Point; and less
2. any Payments which exceed any limitations of coverage under this **Policy** or which are excluded under this Policy; multiplied by
3. the **Aggregate Reimbursement Percentage**.

[In no event will the Aggregate Excess Loss benefit exceed the Maximum Aggregate Reimbursement specified under Aggregate Excess Loss Coverage in the **Schedule**.]

If for any reason, **Your** Aggregate Excess Loss coverage terminates before the end of the **Policy Period**:

1. all coverage under this **Policy** will end immediately;
2. the **Run-Out Period**, if any, will not apply; and
3. the Minimum **Annual Aggregate Attachment Point** shown in the **Schedule** will continue to apply and will not be reduced.

SECTION IV.
REIMBURSEMENT OF ADDITIONAL COVERAGES

Plan Benefits which **You** have **Paid** under **Your** prescription drug plan, vision plan, or dental plan will only be considered for reimbursement by **Us** under the Specific Excess Stop- Loss Policy if such coverages are as included on the **Schedule**.

Plan Benefits which **You** have **Paid** under **Your** prescription drug plan, vision plan, and/or dental plan, will only be considered for reimbursement by **Us** under the Aggregate Excess Stop- Loss Policy if such coverages are included on the **Schedule**.

SECTION V.
LIMITATIONS

Actively at Work Status and Disabled Persons

We will only reimburse **Covered Services Incurred** by individuals who, on the latter of the Effective Date of their coverage under **Your Plan** or the Effective

Date of this **Policy** are eligible employees or their eligible dependents under the **Plan.**

Disabled Persons
If applicable, Expenses **Incurred** will not be eligible to satisfy the **Specific Attachment Point** or the **Annual Aggregate Attachment Point** until the day next following the date the **Covered Person**, with respect to an employee, returns to work on a full-time basis as defined in **Your Plan**. This limitation only applies to **Covered Persons** whose coverage under **Your Plan** is effective on or after the Effective Date of this Policy.

Disclosure
We have relied upon the information provided by **You** and **Your TPA** in the issuance of this Policy. Should subsequent information become known which was requested by us and not provided to us by **You**, if known prior to issuance of this Policy, would affect the premium rates, factors, terms or conditions for coverage thereunder, **We** will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to **You**. Any fraudulent statement will render this **Policy** null and void and claims, if any, will be forfeited.

Retired Employees
We will reimburse **Paid Plan Benefits** for Retired Employees and their dependents, who are eligible under the **Plan** only if such persons are indicated as included in the **Schedule**.

COBRA Continuees
With respect to those persons qualifying as **COBRA Continuee**s, and continuing coverage under **Your Plan** as such, prior to, on or after the Effective Date of this Policy, **We** will reimburse **Paid Plan Benefits** for such individuals only if **You** make timely notification to such individuals of their rights to COBRA continuation coverage.

Drug or Alcohol Abuse
If **Your Plan** covers treatment of drug or alcohol abuse, **Plan Benefits** reimbursable under this **Policy** for such treatment will be limited to the amount stated in the **Schedule**.

Liability for Reimbursement
We shall not be liable under this **Policy** to directly reimburse any **Covered Person** or provider of professional or medical services for any benefits that **You** have agreed to provide under the terms of the **Plan**. **Our** sole liability is to **You**, in accordance with the terms of this Policy. **You** may not assign any Excess Loss benefits to **Covered Persons** or providers of services.

SECTION VI.
EXCLUSIONS (What is Not Covered under the Policy)

In addition to the Exclusions listed in the PPO/HMO member booklet/certificate or **Plan,** the following exclusions will apply under this **Policy.**

We will not reimburse you for any losses or expenses caused by or resulting from:

1. Any expenses **Incurred** while **Your Plan Document** is not in force with respect to the **Covered Person**, or for a person not covered under your **Plan Document**.
2. Any expenses covered by **Plan Document** changes made prior to **Our** written approval of such changes.
3. Any expenses resulting from any prescription card service, mail order prescription plan or any pre-paid prescription drug plan, dental plan or vision plan, unless selected as indicated in the **Schedule of Excess Stop-Loss Insurance**.
4. Any liability or obligations assumed by you under any contract or service agreement other than your **Plan Document**.
5. Any expenses for services or supplies which are in violation of any law.
6. Any expenses for services or supplies billed above the reasonable and customary charges for the area where provided or which are greater than your **Plan Document** benefit.
7. Any cost of the administration of claims, including cost of investigation, payments, or other service(s) provided by your **TPA**, consulting fees or expenses of any litigation.
8. Any expenses from an act while committing or attempting to commit an illegal act or felony, whether or not the **Covered Person** is arrested or prosecuted.
9. Any amount used to satisfy deductibles or coinsurance amounts under **Your Plan Document**.
10. Any expenses or any costs resulting from non-contractual damages, court costs and legal fees, including but not limited to compensatory, exemplary and punitive damages, fines or statutory penalties.
11. Any payments recoverable through the Coordination of Benefits or similar provision of **Your Plan Document**.
12. Any affiliated or subsidiary company not included in the **Schedule of Excess Stop-Loss Insurance**, unless added by rider to this “policy”.
13. Any legal expenses or fees.
14. Any expenses **Incurred** after the Expiration Date of the **Policy** or **Your Plan Document**, whichever occurs first.

15. If this **Policy** is terminated before the Expiration Date, any expenses **Incurred** after the date of such termination.
16. Any expenses **Incurred** by any COBRA continuee whose COBRA continuation coverage was not offered in a timely manner as defined by COBRA laws.

SECTION VII.
PREMIUMS AND FACTORS

Payments of Premiums
No coverage under this **Policy** will be in effect until the first premium is **Paid**. For coverage to remain in effect, each subsequent premium must be **Paid** on or before the **Premium Due Date**. **You** are responsible for the payment of premiums. Payment of the premium to **Your TPA** does not constitute payment of the premium to **Us**. Premium is not considered **Paid** until the premium check is received at **Our** Underwriting Office and sufficient funds are transferred from **Your** account into **Our** account and clear

Upon termination of this Policy, or coverage hereunder, if the earned premium exceeds the premium **Paid**, **You** will pay the excess to **Us**; if less, **We** will return to **You** the unearned portion of premium **Paid**, subject to the minimum premium, if any, shown in the **Schedule**.

Grace Period
A Grace Period of 31 days from the due date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the coverage will remain in effect, provided the premium is **Paid** before the end of the Grace Period. If **You** do not pay the premium during the Grace Period, this **Policy** will terminate without further notice, retroactive to the date for which premiums were last **Paid**.

Changes in Premium Rates or Factors
We may change **Your** premium rates and/or Monthly Aggregate Excess Loss Factors on any of the following dates:

1. The date when the terms of this **Policy** are changed.
2. The date **You** add or delete subsidiary or affiliated companies or divisions with **Our** approval.
3. The date **You** change **Your Plan** with **Our** written approval.
4. The date there is a change in the geographical area in which **You** are located.
5. The date there is a change in the nature of business in which **You** are engaged.

We reserve the right to recalculate the premium rates and/or the Monthly Aggregate Excess Loss Factors retroactively up to one year for the **Policy Period**, if there is more than 10% variance between:

1. the number of **Covered Units** on any **Premium Due Date**; and
2. the number of **Covered Units** on the **Policy** Effective Date.

Otherwise, **We** will not change **Your** premium rates or Monthly Aggregate Excess Loss Factors during the **Policy Period**.

SECTION VIII.
TERMINATION

This **Policy** and all coverage hereunder will end upon the earliest of the following:

1. At the end of any period for which the premium is **Paid**, if the subsequent premium is not **Paid** as provided in the Grace Period provision.
2. On the date **You** tell **Us You** want to cancel this Policy, provided **You** have given **Us** at least 31 days advance written notice. If **You** cancel within 30 days after the Effective Date, **You** may ask for a full refund of the premium. If **You** do so, this **Policy** will terminate on the Effective Date. If **You** cancel this **Policy** at a later date, **We** may keep the premium earned to the date of termination.
3. The Expiration Date of this Policy.
4. On the Effective Date, if, within 60 days after the Effective Date:
    1. **You** fail to provide **Us** any information or materials requested by **Us**; or
    2. **You** fail to comply with any condition imposed by **Us** when this **Policy** is issued.
    If so, **We** will return the premium **Paid** by **You**, less the amount of any reimbursements **We** made to **You** before the time this **Policy** was terminated. If the amount reimbursed to **You** exceeds the premium **Paid** to **Us**, **You** will pay **Us** the difference.
5. The date the **Plan** terminates.
6. The date the administrative services agreement between **You** and **Your TPA** terminates, unless **We** consent in writing to **Your** naming of a new **TPA**.
7. The last day of the third consecutive month during which **You** fail to maintain the Minimum Plan Enrollment as stated in the **Schedule**, unless **We** agree in writing to continue coverage;
8. The date **You**:
    1. Suspend active business operations; or

2. are placed in bankruptcy or receivership, or
3. dissolve.

9. Any date on which **You** do not pay claims or make funds available to pay claims as required by the **Plan**.

Concealment or Fraud
This entire **Policy** will be void:

1. if, before or after a claim or loss, **You** or **Your TPA** have concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim; (This includes failure to provide the required disclosure of health history of Disabled Persons, **Large Claims** or **Potentially Catastrophic Loss**es.) or
2. in any case of fraud by **You** or **Your TPA** relating to this coverage.

SECTION IX.
REINSTATEMENT

We may, at **Our** option, approve **Your** request to reinstate this Policy. **You** shall submit to **Us** any forms and data **We** may require, including **Your** representation as to losses **Incurred** or **Paid** as of the date of **Your** request for reinstatement. If this **Policy** is reinstated, **You** shall pay to **Us** the premiums due from the date this **Policy** terminated.

SECTION X.
CLAIM PROVISIONS

Administration of Claims under Your Plan
We have no duty to settle or adjust claims filed under **Your Plan**. **You** must retain and pay a **TPA** at all times. **We** will not reimburse **You** for **Plan Benefits** resulting from benefits **Paid** by someone not authorized to do so.

You must make available sufficient funds to pay benefits when due.

The **TPA** shall:

1. supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims, in accordance with the **Plan**;
2. maintain accurate records of all claim Payments;
3. maintain separate records of expenses not covered; and
4. provide **Us**, on or before the 15th day of each **Policy Month**, the following data for the preceding **Policy Month**:
   1. number of **Covered Persons** and/or **Covered Units**; and
   2. a total of claims **Paid**.

Management of Large Claims (LC's) and Potentially Catastrophic Losses (PCL's)
Notice of **LC** – **You** or **Your TPA** must notify **Us** in writing of any LC (regardless of whether charges have been **Paid** or are pending Payment) as soon as practically possible when the claim exceeds or it appears that the claim will reach or exceed the defined limits for a LC.

Notice of PCL – **You** or **Your TPA** must notify **Us** in writing of any PCL as soon as practically possible when receiving any information indicating that the claim (regardless of whether charges have been **Paid** or are pending Payment) is potentially catastrophic. (See Exhibit I of this Policy.)

Notice of Claim
Specific Excess Loss – **You** must give written notice of claim to **Us** within 30 days of the date **You** become aware of claims, with respect to a **Covered Person**, that have reached 50% of the **Specific Attachment Point**; however, **LC's** and **PCL's** should be reported within the time frame specified in the previous paragraph.

Aggregate Excess Loss – **You** must give written notice of claim to **Us** within 30 days of the date **You** become aware of claims that have reached the Annual Aggregate Attachment Point.

Your failure to furnish written notice within the time required by this **Policy** will not invalidate or reduce any claim if it was not reasonably possible to provide written notice within such time. However, written notice must be furnished as soon as possible, but in no event later than one year after the date written notice is first required.

You or **Your TPA** shall submit on a timely basis all proofs of claims, reports and supporting documents **We** may request.

Proof of Loss
Written proof of loss must be submitted within 60 days after the date of loss. Late proof will be accepted only if it is shown to have been furnished as soon as reasonably possible and within one year of the date of loss.

Payment of Claims
Amounts payable under this **Policy** will be **Paid** upon receipt and acceptance by **Us** of all the required material. Required material shall include proof of loss and proof of Payment for Eligible Expenses under the **Plan** and any reasonably requested supporting documentation.

Benefit Determination
Determination of benefits under **Your Plan** is **Your** sole responsibility. **We** have no duty to settle or adjust claims filed under the **Plan** with **You** or **Your TPA**. **We** have the right to review each claim **You** submit to **Us** for reimbursement to determine if **You** are entitled to reimbursement.

Recoveries/Subrogation
You are required to investigate and prosecute all valid claims that **You** may have against third parties arising out of any claim for which benefits were **Paid** by the **Plan**. **You** or **Your TPA** shall account to **Us** for all amounts recovered. If **You** fail to pursue any action against a third party and **We** have made benefit payments under this Policy, **We** will be subrogated to all of **Your** rights to make recoveries unless the **TPA** advises us otherwise in writing. **You** are required to cooperate fully and do all things necessary and required for **Us** to pursue any action to recover against the third party.

Any amounts recovered by **You**, **Your TPA**, or the **Covered Person** in such action shall be used first to reimburse the **TPA** for any benefit Payments made on behalf of any **Covered Person**, and then to reimburse the expenses of recovery. Any amounts recovered by **Us** shall be used to reimburse **Us** for any amount that **We** may have **Paid** or become liable to reimburse to **You** under the terms of this Policy, and then to reimburse the expenses of collection. All remaining amounts shall be **Paid** to **You**. If **We** have reimbursed **You** for all or part of a particular loss and **You** or **Your Plan** later recover for that loss from a third party, **You** must repay **Us** to the extent of **Our** reimbursements, regardless of whether this **Policy** is still in force on the date **You** recover.

Notice of Appeal
Any objection, notice of legal action, or complaint received on a claim processed under **Your Plan** on which it reasonably appears an Excess Loss benefit will be payable to **You** under this **Policy** shall be brought to the immediate attention of **Our** Underwriting Office.

SECTION XI.
GENERAL PROVISIONS

If premium taxes should be assessed against **You** with respect to claims **Paid** under **Your Plan**, **You** shall hold **Us** harmless from any tax liability.

Entire Contract
This entire contract consists of:

1. this Policy, including any **Endorsement**s;
2. **Your Application** and **Schedule** and any attachments thereto, a copy of which is attached to this Policy, and
3. a copy of **Your Plan**.

All statements made by **You** or any **Covered Person** are, in the absence of fraud, understood to be representations and not warranties. Such statements will not be used to contest coverage unless contained in the **Application** and **Schedule** or any attachments to the **Application** and **Schedule**.

In case of a conflict between the **Plan** and this Policy, [the **Plan][**the **Policy]**. **We** have relied on the information **You** provided to issue this Policy. **You** represent such information is accurate. Should subsequent information become known which **We** asked for and you did not provide to us, if known prior to issuance of this Policy, would affect the premium rates, factors, terms or conditions for coverage thereunder, **We** will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to **You**. Any fraudulent statement will render this **Policy** null and void and claims, if any, will be forfeited.

Policy Nonparticipating
This **Policy** does not entitle **You** to share in **Our** earnings.

Records and Review
You and/or **Your TPA** must:

1. keep appropriate records regarding administration of **Your Plan**; (**Your** records include records held by **Your TPA**.)
2. allow **Us** to review and copy, during normal business hours, all records affecting **Our** liability under this Policy;
3. maintain records of all **Covered Persons** under the **Plan** during the **Policy Period** and for a period of seven years after the termination of this Policy; and
4. maintain a separate record of any and all amounts **You** pay that exceed or are not covered by the benefits under **Your Plan**.

Clerical Error
If **You** or **We** make a clerical error keeping records or calculating premiums or claims pertaining to this Policy, it will not invalidate this Policy. A clerical error will not expand **Our** obligations under this Policy. A clerical error is a mistake in performing a clerical function, and does not include intentional acts or failure to comply with **Plan** or **Policy** provisions. A clerical error is not the failure to disclose the required disclosure of health history of Disabled Persons, **Large Claims** or **Potentially Catastrophic Losses**.

Changes to This Policy
Changes to this **Policy** may be made only by a **Company** officer or **Our** Underwriting Office, with **Our** approval. Any change must be by written **Endorsement**.

Changes to Your Plan
We must be notified of any changes to the **Plan** which affect this Policy. This notice must be in writing and provided to **Us** at least 31 days prior to the effective date of the change. **We** must approve the change in writing before coverage affected by this change will be provided by this Policy. If **We** do not receive advance written notice of the change, or **We** decline coverage of the changes under this Policy, **We** will be liable only for benefits provided by the **Plan** prior to the change **You** must provide **Us** with a copy of **Your** written **Plan** and all amendments prior to the time the change becomes effective.

Subsidiaries, Affiliated Companies Under Your Plan
You must notify **Us** in the event **You** acquire a subsidiary or affiliated company that will be included under **Your Plan**. If **You** do acquire a subsidiary or affiliated company that will be included under **Your Plan**, **You** must disclose certain required health history on persons whose coverage **You** will be assuming under **Your Plan**. Failure to do so will subject benefits under this **Policy** to certain limitations, as described in "Disclosure" in Section V.

Acquisition of a subsidiary of affiliated company that will be included under **Your Plan** may affect **Your** premium rates and/or Monthly Aggregate Excess Loss Factors, as described in "Changes in Premium Rates or Factors," in Section VII.

You must notify **Us** in the event **You** cede or dissolve a subsidiary or affiliated company that was included under **Your Plan**. Failure to do so may subject this **Policy** to termination (if Minimum Plan Enrollment is not maintained), or may affect **Your** premium rates and/or Monthly Aggregate Excess Loss Factors, as described in "Changes in Premium Rates and Factors," in Section VII.

Duties and Responsibilities of Your Designated Third –Party Administrator (TPA)
Your TPA must be approved by **Us**.

We agree to recognize **Your TPA** as **Your** agent for the administration of **Your Plan**. **You** agree that **Your TPA** will:

1. administer and pay all claims for **Covered Services** under the **Plan**;
2. prepare reports required by **Us** and keep and make available to **Us** data **We** may require; and
3. do what is necessary for **You** to comply with the terms of this Policy.

You will pay **Your TPA** for all administrative functions performed in relation to this Policy.

Your TPA is **Your** agent and not **Ours**. **You** authorize **Your TPA** to:

1. submit Notice/Proof of Loss;
2. certify the Payment of claims;
3. transmit reports and payment of premiums to **Us**; and
4. receive payments from **Us**.

Payments by **Us** to **Your TPA** are payments to **You**.

Notice
For the purpose of any notice required from **Us** under the terms of this Policy, notice to **Your TPA** is notice to **You** and notice to **You** is notice to **Your TPA**.

Disclaimer
We act only as a provider of Excess Stop- Loss Insurance coverage to **Your Plan**. **We** are not a fiduciary. **We** do not assume any duty to perform any of the functions or provide any of the reports required by the Employee Retirement Income Security Act of 1974, as amended.

We have no right or obligation to pay any **Covered Person** or provider of professional or medical services. **Our** sole liability is to **You**, subject to the terms and conditions of this Policy. Nothing in this **Policy** shall be construed to permit a **Covered Person** to have a direct right of action against **Us**. **We** will not be considered a party to **Your Plan** or to any supplement or amendment to it.

Indemnification, Defense and Hold Harmless
You agree to release and hold **Us** harmless from any damages, liabilities, expenses, costs of defense and losses which result directly from:

1. any dispute involving a **Covered Person** unless it is a result of **Our** sole negligence or intentional wrongful acts; and
2. any State premium taxes **We** are assessed with respect to funds **Paid** by or to **You** under **Your Plan**. Taxes on amounts **Paid** to Us as premiums for this **Policy** are excluded.

We will notify **You** if **We** believe that **You** may have obligations to hold **Us** harmless under this Policy. **We** may participate in the defense at **Our** own expense. If **You** do not act promptly in that **We** may be prejudiced by **Your** inaction, **We** may defend and compromise or settle the claim or other matter on

Your behalf, for **Your** account, and at **Your** sole expense.

Offset
We may offset payments due **You** under this **Policy** against claim overpayments and premium due and unpaid.

Assignment
You may not assign any of **Your** rights under this Policy.

Severability
Any clause deemed void, voidable, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, will not render any of the remaining provisions of this **Policy** invalid.

Insolvency
The insolvency, bankruptcy, financial impairment, receivership, voluntary plan or arrangement with creditors, or dissolution of **You** or **Your TPA**:

1. will not impose upon **Us** any liability or additional duties other than those defined and provided for in this Policy; (For example, **We** will have no responsibility to pay claims for **Your Plan** to ensure reimbursement under this Policy.) and
2. will not make **Us** liable to **Your** creditors, including **Covered Persons**.

Claims under **Your Plan** must continue to be funded and **Paid** within contractual time frames in order to be eligible for reimbursement under this Policy.

Parties To This Policy:
You and **We** are the only parties to this Policy. **Our** sole liability under this **Policy** is to **You**. This **Policy** does not create any right or legal relation between **Us** and a **Covered Person** under **Your Plan**. This **Policy** will not make **Us** a party to any agreement between **You** and **Your TPA**.

Legal Action
No action at law or in equity shall be brought to recover on this **Policy** prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Time Limit on Certain Defenses
In the absence of fraud, all statements made by **You** OR **Your TPA** shall be deemed representations and not warranties. If these statements appear as part of the written **Application** or other written instrument signed by **You** or **Your TPA**, **We** may use them to contest the Contract. If **We** do, **We** will furnish **You** OR **Your TPA** with a copy of the document in question. After 2 years, only fraudulent misstatements may be used to contest the contract coverage under this Policy.

Arbitration
Any controversy or claim arising out of or relating to this Policy, or the breach thereof, shall be settled by Arbitration in accordance with the rules of the American Arbitration Association, with the express stipulation that the arbitrator(s) shall strictly abide by the terms of this **Policy** and shall strictly apply rules of law applicable thereto. All matters shall be decided by a panel of one (1) arbitrator with a minimum of ten years expertise in the area of excess stop-loss coverage. The arbitrator shall not be a past or present employee, officer, partner, shareholder, and/or director of the parties nor have represented the parties if he/she is a lawyer. Discovery shall be limited to requests for production of documents and interrogatories. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. The prevailing party shall be entitled to its costs and fees **Incurred** in any arbitration proceeding, unless the arbitrator decides otherwise. This provision shall survive the termination or expiration of this Policy. The parties hereto may alter any of the terms of this provision only by express written agreement.

EXHIBIT I

Potentially Catastrophic Losses (**PCL's**). Claims which qualify as **PCL's** are listed below. **We** reserve the right to add to or delete from this list of **PCL's** with 31 days advance written notice to **You**.

HIGH RISK PREGNANCY AND PRE-TERM/NEONATAL

- Premature births –weighing under four pounds and/or less than 36 weeks gestation
- Multiple births (three or more infants) or expected multiple births
- Abnormal respiration/respiratory failure (APNEA)
- Congenital heart defects:
  - Ventricular and atrial septal
  - Patent ductus arteriosus
- Congenital disorders:
  - Spina – Bifida
  - Encephalocele
  - Cephalohematoma
  - Hyaline Membrane Disease
- Birth injuries or major birth traumas
- Congenital Anomalies of Digestive System
- Lack of Expected Normal Physiological Development

- Maternal causes of Prenatal Morbidity and Mortality
- Other conditions originating in the Perinatal Period

CATASTROPHIC DISEASES AND ILLNESSES

- Renal dysfunction/failure, including dialysis treatment
- Cerebral vascular accident (stroke)
- Diabetes with complications

TRAUMA

- Spinal cord injuries
- Coma
- Massive internal injuries
- Traumatic brain injury
- Brain lesion or tumors
- Multiple or serious fractures
- Severe burns (10% or more of the body with 3rd degree burns, or 30% of the body with 2nd degree burns)
- Trauma to the elderly or chronically ill
- Paralysis of any kind

DISEASE OF THE HEART AND PERICARDIUM

- Myocardial infarction
- Myocarditis
- Coronary Artery Disease
- Multiple Bypass
- Cardiomyopathy

CANCER

HIV Positive or AIDS (Acquired Immune Deficiency Syndrome) Related Illnesses, such as;

- Kaposi's sarcoma
- Cytomegalovirus
- Pneumocystics carinii pneumonia

ORGAN TISSUE, BONE MARROW, OR STEM CELL TRANSPLANT EVALUATION, PROCEDURE OR SURGERY

EXTENDED ILLNESS OR INJURY

- Chronic Liver Disease
- Multiple Sclerosis or Muscular Dystrophy or Cystic Fibrosis or Cerebral Palsy or Degenerative Muscular Disease
- Any illness or injury which requires intensive and prolonged treatment (such as nutritional support systems, intravenous therapies, and ventilators)
- Continuous hospitalization of 2 weeks or more
- Amputations
- Home health care greater than 20 days
- Hospitalization of $40,000 or more
- Interim/Cycle hospital billings
- Hospitalization during pregnancy, prior to delivery, or for high-risk pregnancy.
- Mental disorders requiring hospital confinement
- HepatitisC
- Multiple hospitalizations of three or more per year
- Inpatient admission greater than 10 days.

Wesco Insurance Company

ADVANCED FUNDING ENDORSEMENT

ENDORSEMENT NUMBER:

ENDORSEMENT EFFECTIVE DATE:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

POLICYHOLDER:

ENDORSEMENT SCHEDULE

Advanced Funding Amount:
Required Proof Period:
Specific Deductible Due Date:
Processing Period:
Requests Due Date:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

As of the Endorsement Effective Date above, this endorsement is attached to and made part of the **Policy**. Regardless of anything in the **Policy** to the contrary, this endorsement changes the **Policy** as follows:

1. **We** will pay up to the Specific Benefit Limit shown on the Schedule of Excess Stop-Loss Insurance after acceptance by **Us** of proof of payment of **Plan Benefits** under **Your Plan Document**. Before each Advanced Funding request is submitted, **Plan Benefits** must exceed the **Specific Attachment Point** by at least the Advanced Funding Amount shown in the **Endorsement** Schedule above.

2. The continued availability of Advanced Funding is subject to the following conditions:

    a. **You** must provide **Us** a copy of the front of the check payable to the medical service provider (or other proof of payment acceptable to **Us**) within the Required Proof Period shown in the **Endorsement** Schedule above; and

    b. **You** must provide **Us** a copy of the front and back of the cancelled check payable to the medical service provider (or other proof of payment acceptable to us) within thirty (30) days of the receipt of the Advanced Funding payment from **Us**.

3. If **We** do not receive proof of payment as outlined above, **We** reserve the right to pay claims as outlined in **SECTION X, CLAIM PROVISIONS** of the **Policy**.

4. Advanced Funding on **Plan Benefits** in excess of the **Specific Attachment Point** is available to **You** upon meeting all the requirements listed below:

    a. The **Specific Attachment Point** must be paid in full by **You** prior to any claims being considered for Advanced Funding. Payment of the **Specific Attachment**

Point must be made by the Specific Deductible Due Date shown in the **Endorsement** Schedule above;

b. The **Plan Benefits** must be equal to or greater than the Advanced Funding Amount shown in the **Endorsement** Schedule above;
c. The **Plan Benefits** submitted for Advanced Funding must have been fully processed according to the terms of **Your Plan Document** by **Your TPA** and must be ready for payment;
d. Claim audit procedures will be implemented before we release any reimbursements;
e. **Your** payment for **Plan Benefits** must be released to a medical service provider within the Processing Period shown in the **Endorsement** Schedule above. If **Your** payments are not made within the Processing Period shown in the **Endorsement** Schedule above, our reimbursement must be returned to **Us**;
f. Any portion of **Our** reimbursement not used to reimburse **Plan Benefits**, due to discounts or any other reason, must be returned to **Us** within the Processing Period shown in the **Endorsement** Schedule above;
g. All initial or subsequent Advanced Funding requests must be received by **Us** by the Requests Due Date shown in the **Endorsement** Schedule above. Any requests received after that date are not eligible for Advanced Funding and, therefore, must be fully paid by **You** within the **Benefit Period** in order to be covered under the **Policy**.

5. This endorsement shall terminate:

a. Immediately, in the event premiums are not paid on a timely basis and coverage lapses; or
b. Simultaneously with the termination of the **Policy**, if the **Policy** is terminated for any reason other than a. above.

Wesco Insurance Company

AGGREGATE EXCESS LOSS
TERMINAL LIABILITY ENDORSEMENT

ENDORSEMENT NUMBER:

ENDORSEMENT EFFECTIVE DATE:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

POLICYHOLDER:

ENDORSEMENT SCHEDULE

Required Notification:
Benefit Period:
Monthly Aggregate Factors and Covered Units:
Aggregate Terminal Liability Premium:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

As of the Endorsement Effective Date above, this endorsement is attached to and made part of the **Policy**. Regardless of anything in the **Policy** to the contrary, this endorsement changes the **Policy** as follows:

1. If, no later than the Required Notification days shown in the Endorsement Schedule above, before the Expiration Date of the **Policy**, **You** notify us of **Your** intent not to renew the **Policy**, the **Benefit Period** shown in item 2. and the **Monthly Aggregate Factors** and **Covered Units** shown in item 8. under section **B. AGGREGATE EXCESS LOSS INSURANCE** of the Schedule of Excess Stop-Loss Insurance are changed as shown in the Endorsement Schedule above.

2. All Aggregate Excess Loss Insurance benefits payable under the **Policy** will be calculated, or re-calculated, based on the **Benefit Period** and **Monthly Aggregate Factors** shown above. Coverage will be provided under this endorsement for **Plan Benefits** only: a) to the extent that such **Plan Benefits** are not eligible for coverage under any other group policy; and b) if **Covered Persons** will be covered under fully-insured medical insurance immediately following the Expiration Date of the **Policy**.

3. This endorsement is added to the **Policy** in consideration of the Aggregate Terminal Liability Premium shown in the Endorsement Schedule above. The Aggregate Terminal Liability Premium is non-refundable and payable in full on the Endorsement Effective Date.

4. If this **Policy** terminates prior to its Expiration Date, no Aggregate Excess Loss Insurance Benefits will be payable and premium paid will not be refundable.

Wesco Insurance Company

AGGREGATING SPECIFIC LIABILITY ENDORSEMENT

ENDORSEMENT NUMBER:

ENDORSEMENT EFFECTIVE DATE:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

POLICYHOLDER:

Aggregating Specific Liability Limit:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

As of the Endorsement Effective Date above, this endorsement is attached to and made part of the **Policy**. Regardless of anything in the **Policy** to the contrary, this endorsement changes the **Policy** as follows:

1. **You** hereby agree to retain the amount of **Plan Benefits** which exceeds the **Specific Attachment Point** shown on the Schedule of Excess Stop-Loss Insurance equal to the Aggregating Specific Liability Limit shown in the **Endorsement** Schedule above. **Your** Aggregating Specific Liability Limit is not eligible for reimbursement under the **Policy**.

2. The Aggregating Specific Liability Limit shown in the **Endorsement** Schedule above:

   a. Is determined at the start of the **Policy Period**;
   b. Is based on the size of the **Specific Attachment Point** and overall premium level and in accordance with **Our** actuarial tables;
   c. Is satisfied by an individually **Incurred Plan Benefit** or multiple **Incurred Plan Benefits**;
   d. Must be paid in its entirety by **You** before the balance of any **Plan Benefits** in excess of the **Specific Attachment Point** is reimbursed to **You** by **Us** in accordance with the **Policy**;
   e. Must be satisfied only once during the **Policy Period.**

Wesco Insurance Company

MONTHLY CUMULATIVE ACCOMMODATION FOR AGGREGATE EXCESS LOSS ENDORSEMENT

ENDORSEMENT NUMBER:

ENDORSEMENT EFFECTIVE DATE:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

POLICYHOLDER:

ENDORSEMENT SCHEDULE

Minimum Threshold:
Refund Due Date:
Penalty:
Year-End Reimbursement Due Date:
Due Date if Canceled:
Due Date if Policy Terminated:
Reporting Period:
Monthly Cumulative Accommodation Premium Rate:
[Provisional Monthly Cumulative Accommodation Premium:]

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

1. Monthly Cumulative Accommodation

If, at the end of a **Policy Month**, **Your Cumulative Eligible Expenses** exceed the **Cumulative Aggregate Attachment Point** by an amount greater than the Minimum Threshold shown in the Endorsement Schedule above, **We** will release to **You** the amount by which **Your Cumulative Eligible Expenses** exceed the **Cumulative Aggregate Attachment Point** for that month.

2. Definitions

For the purposes of this endorsement, the following definitions apply:

a. **Cumulative Aggregate Attachment Point** means the greater of:

1) The sum of the monthly aggregate attachment point for all **Policy Months** of the **Cumulative Period**; or
2) The monthly aggregate attachment point for the first month of the **Policy Period**, times the number of **Policy Months**.

b. **Cumulative Eligible Expenses** means the total amount of **Plan Benefits** that **You** have paid under **Your Plan Document** during the **Cumulative Period**.

Cumulative Eligible Expenses do not include amounts:

1) We have paid to **You**, or **You** are eligible to receive, as Specific Excess Loss-Loss Coverage benefits during the **Policy Period**;
2) Paid under **Your Plan Document** which exceed the Specific benefit limit shown on the Schedule of Excess Stop-Loss Insurance; or
3) Which are not **Plan Benefits.**

c. **Cumulative Period** means the period which:

1) Begins on the Effective Date of the **Policy** or, if later, on the Endorsement Effective Date; and
2) Ends on the last day of the summation of each and every **Policy Month** after the first, and prior to the last, month of the **Policy Period**.

d. **Net Amount** means all amounts that **We** have released to **You**, less the amounts that **You** have returned to **Us** under this endorsement.

3. Amounts Released

Amounts Released by Us:

a. Will always be considered **Our** funds;
b. Will be subject to all the terms of the **Policy**, including but not limited to **Our** receipt of **Your** request for reimbursement, and proof of claim satisfactory to **Us**;
c. Will not exceed the Aggregate benefit limit shown on the Schedule of Excess Stop-Loss Insurance payable by **Us**; and
d. Are not loans or advances of benefits payable under the **Policy**.

We will only release amounts under this endorsement if **You** have paid to **Us**:

a. All premiums due through the **Cumulative Period**; and
b. All amounts which **You** are required to return to **Us**, in accordance with the **Repayment of Amounts Released** section below.

4. Repayment of Amounts Released

Amounts released under this endorsement must be returned to **Us** by **You**, in their entirety, if, during any subsequent **Policy Month**, **Your Cumulative Aggregate Attachment Point** is greater than **Your Cumulative Eligible Expenses.**

Your refund to **Us**:

a. Will not exceed the amount **We** have released to **You** under this endorsement;
b. Will not be carried over into any subsequent **Policy Month**, or **Policy Period**; and
c. Is due and payable within the Refund Due Date shown in the Endorsement Schedule above.

5. Year-end Adjustment

At the end of the **Policy Period**, **We** will determine the **Annual Aggregate Attachment Point** without regard to this endorsement.

We will reimburse **You**, for any amount by which **Cumulative Eligible Expenses** are in excess of the greater of:

a. The **Annual Aggregate Attachment Point**, or
b. The **Minimum Aggregate Attachment Point"** less any **Net Amounts** previously paid.

We will reimburse **You** only if all due premium is paid, and all amounts **You** must return to **Us** under this endorsement have been paid to **Us**.

You must reimburse **Us** for any amount by which the greater of a. or b. below exceeds the **Cumulative Eligible Expenses**:

a. The **Annual Aggregate Attachment Point**, or
b. The **Minimum Aggregate Attachment Point**.

No benefits will be paid under the **Policy** or under this endorsement until **We** have received all amounts **You** must return to **Us** under this endorsement. If **You** do not pay amounts due within the time allowed:

a. We reserve the right to reduce any benefits payable under other terms of the **Policy** by such amounts;

b. **You** shall be assessed a penalty equal to the Penalty shown in the Endorsement Schedule above; and
c. **You** will be liable for all costs and expenses, including attorney fees, which **We** incur in the collection of such amounts.

You must reimburse amounts due **Us** by the Year-end Reimbursement Due Date shown in the Endorsement Schedule above.

6. Termination Prior to End of Policy Period

If the **Policy** is canceled or terminated prior to the end of the **Policy Period**, **You** must return to **Us** all amounts **We** have released to **You** under this endorsement.

You must reimburse amounts due **Us** by the Due Date if Canceled shown in the Endorsement Schedule above.

7. Termination of this Endorsement

This endorsement shall terminate automatically upon termination of the **Policy**, or the **Plan Document.** Termination of this endorsement shall not terminate **Your** obligations to return to **Us** amounts due **Us** under this endorsement.

You must reimburse amounts due **Us** by the Due Date if Policy Terminated shown in the Endorsement Schedule above.

8. Reporting Requirements

You must submit to **Us**, within the Reporting Period shown in the Endorsement Schedule above, a report of **Plan Benefits** paid by **You** during that month.

9. Premium

This endorsement is added to the **Policy** in consideration of the Monthly Cumulative Accommodation for Aggregate Excess Loss premium. The [minimum and provisional] premium is calculated by multiplying the Monthly Cumulative Accommodation Rate shown in the Endorsement Schedule above by the [actual] number of **Covered Units** [as of the first day of each month.][shown in item 8. under section **B. AGGREGATE EXCESS LOSS INSURANCE** of the Schedule of Excess Stop-Loss Insurance multiplied by twelve (12). The minimum and provisional premium is non-refundable and payable in full on the Endorsement Effective Date.

Premium shall be adjusted within thirty-one (31) days of the earlier of the end of the **Policy Period** or the date of termination or cancellation of the **Policy** and shall be the greater of:

a. The Monthly Cumulative Accommodation Rate shown in the Endorsement Schedule above multiplied by the number of **Covered Units** shown in item 8. under section **B. AGGREGATE EXCESS LOSS INSURANCE** of the Schedule of Excess Stop-Loss Insurance multiplied by 12 (twelve); or
b. The Monthly Cumulative Accommodation Rate shown in the Endorsement Schedule above multiplied by the number of actual monthly **Covered Units** as reported to **Us** during the **Policy Period**; or
c. The Provisional Monthly Cumulative Accommodation Premium shown in the Endorsement Schedule above.]

Wesco Insurance Company

FAMILY SPECIFIC ATTACHMENT POINT ENDORSEMENT

ENDORSEMENT NUMBER:

ENDORSEMENT EFFECTIVE DATE:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

POLICYHOLDER:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

As of the Endorsement Effective Date above, this endorsement is attached to and made part of the **Policy**. Regardless of anything in the **Policy** to the contrary, this endorsement changes the **Policy** as follows:

The **Specific Attachment Point** shown in the Schedule of Excess Stop-Loss Insurance will apply to each family of **Covered Persons** and not to each **Covered Person**.

Wesco Insurance Company

SPECIFIC EXCESS LOSS TERMINAL LIABILITY ENDORSEMENT

ENDORSEMENT NUMBER:

ENDORSEMENT EFFECTIVE DATE:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

POLICYHOLDER:

ENDORSEMENT SCHEDULE

Required Notification:
Benefit Period:
Specific Terminal Liability Premium:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

As of the Endorsement Effective Date above, this endorsement is attached to and made part of the **Policy**. Regardless of anything in the **Policy** to the contrary, this endorsement changes the **Policy** as follows:

1. If, no later than the Required Notification in the **Endorsement** Schedule above, **You** notify **Us** of **Your** intent not to renew the **Policy**, the **Benefit Period** shown in item 2. under section **A. SPECIFIC EXCESS LOSS INSURANCE** of the Schedule of Excess Stop-Loss Insurance is changed as shown in the **Endorsement** Schedule above.

   All Specific Excess Loss Insurance benefits payable under the **Policy** will be calculated, or re-calculated, based on the **Benefit Period** shown above. Coverage will be provided under this endorsement for **Plan Benefits** only: a) to the extent that such **Plan Benefits** are not eligible for coverage under any other group policy; and b) if **Covered Persons** will be covered under fully-insured medical insurance immediately following the Expiration Date of the **Policy**.

2. This endorsement is added to the **Policy** in consideration of the Specific Terminal Liability Premium, shown in the Endorsement Schedule above. The Specific Terminal Liability Premium is non-refundable and payable in full on the Endorsement Effective Date.

3. If this **Policy** terminates prior to its Expiration Date, the **Benefit Period** will not extend past the date of termination. In addition, the **Specific Attachment Point** per **Covered Person** will apply as if the **Policy** were in force for the entire **Policy Period.**

Wesco Insurance Company

DISCLOSURE FORM

[MGU]

Instructions for Completing this Disclosure Form

HIPAA Privacy permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Plan Sponsor as part of "health care operations". [MGU and the Company] shall use the information provided solely for the purpose of evaluating the acceptability of this risk and shall not disclose any PHI collected except in performing this risk evaluation.

[MGU and the Company] will rely upon the information provided in this Disclosure Form, which will become part of the application for stop loss coverage. The purpose of this Form is to allow [MGU, on behalf of the Company,] to take underwriting action on all known individuals in the categories listed below. It is the Plan Sponsor's responsibility, either directly or through their designated representative, to accurately report all claims known as of the date of this Disclosure by making a thorough review of all applicable records. Such record shall include historical claim reports, disability records, payroll records, current information from administrators, insurers, utilization management companies, managed care companies and any Agent/Broker of the Plan Sponsor. In exchange, the Company will accept the liability for any truly unknown claimants. This Disclosure Form must be completed and signed by the appropriate parties no earlier than thirty (30) days prior for new business (or earlier than thirty (30) days if prior approval is authorized by [the MGU underwriter]) and no later than ten (10) days after, the proposed Effective Date of stop loss coverage and received by [MGU] within five (5) days (non-business) of completion.

Upon receipt of this completed Disclosure, [MGU] will assess all data, new and previously reported, and will inform the producer in writing within seven (7) days (non-business) of any changes to the rates, factors or terms of coverage. [MGU, on behalf of the Company,] reserves the right to rescind the proposal in its entirety based upon a review of all information submitted during the proposal process.

When completing this Form, remember that Plan Participants may include those on short or long-term disability, COBRA, FMLA, leave of absence, extension of benefits, sick time, vacation time or retirees covered under the plan and for whom coverage is requested in the quote. All of the Plan Participants for which the above situations apply, should be identified accordingly, e.g., John Smith, COBRA, effective xx/xx/xx. List on this Disclosure Form all Plan Participants who are known to meet any of the following criteria:

1. Currently confined to a Medical Facility, or who have been precertified for same within the last ninety (90) days.
2. Have received medical services during the past twelve (12) months, the cost of which exceeds 50% of the lowest Specific Deductible/Retention applied for, and for which the bills have been received by the Claims Administrator and entered into their claims system.
3. Have been identified as a candidate for Case Management and/or as having the potential to exceed 50% of the lowest Specific Deductible/Retention applied for during the policy period.
4. Have been diagnosed within the past twelve (12) months with a condition represented by any of the ICD-9 codes listed on page 3 of this Form.

If the Plan Sponsor fails to disclose any Plan Participant known to fall into one of the above four categories, either intentionally or because a thorough review of all records was not conducted, the Company will have no liability for claims on the Plan Participant who was not disclosed.

Claimant Identifier	DOB	Sex	Diagnosis	Prognosis	Most Recent DOS	$ Expenses Incurred Last 12 Months

The Plan Sponsor named below represents that the above list accurately discloses all potentially catastrophic claimants in accordance with the instructions contained in this three-page Disclosure Form and that it is the result of a diligent search in accordance with those instructions.

Plan Sponsor:_____ Claims Administrator:_____ Agent/Broker:_____

Signature:_____ Signature:_____ Signature:_____

Name:_____ Name: _____ Name: _____

Title: _____ Title: _____ Title: _____

Date:_____ Date: _____ Date: _____

ICD-9 Codes for Disclosure Notification – Trigger Diagnoses List

Please list all Plan Participants who have been diagnosed with, or treated for, any of the codes listed under the following categories during the current Benefit Period:

001-139 Infectious and Parasitic Diseases

038-038.9	Septicemia
042	AIDS / HIV
070-070.9	Viral Hepatitis

140-239 Neoplasms

140-149.9	Malignant Neoplasm of Lip, Major Salivary Glands, Gum, Mouth, Oropharynx, Nasopharynx, and/or Hypopharynx
150-150.9	Malignant Neoplasm of Esophagus
151-151.9	Malignant Neoplasm of Stomach
153-153.9	Malignant Neoplasm of Colon
154-154.8	Malignant Neoplasm of Rectum
155-155.2	Malignant Neoplasm of Liver
157-157.9	Malignant Neoplasm of Pancreas
161-161.9	Malignant Neoplasm of Larynx
162-162.9	Malignant Neoplasm of Lung
170-170.9	Malignant Neoplasm of Bone
174-174.9	Malignant Neoplasm of Female Breast
179-182.8	Malignant Neoplasm of Uterus or Cervix
183-183.9	Malignant Neoplasm of Ovary
185	Malignant Neoplasm of Prostate
186-186.9	Malignant Neoplasm of Testis
188-189.9	Malignant Neoplasm of Bladder, Kidney, Urinary
191-191.9	Malignant Neoplasm of Brain
192-192.9	Malignant Neoplasm of Nervous System
194-194.9	Malignant Neoplasm of Endocrine Glands
195-195.8	Malignant Neoplasm of Other Ill-Defined Sites
196-196.9	Secondary Malignant Neo. Lymph Nodes
197-197.8	Secondary Malignant Neo. Respty and Digestive Systems
198-198.89	Secondary Malignant Neo. Other Specified Sites
200-208.9	Lymphoma and/or Leukemia
235	Neoplasm Uncertain Behavior
239.2	Neoplasm Unspecified Nature – Bone, Skin

240-279 Endocrine, Nutritional, Metabolic, Immunity

250-250.9	Diabetes
277.0	Cystic Fibrosis
278.0	Obesity/Hyperaliment

280-289 Diseases of the Blood and Blood-Forming Organs

282.6	Sickle-Cell Anemia
284.9	Aplastic Anemia NOS
286-286.9	Coagulation Defects and/or Hemophilia

320-389 Diseases of the Nervous System and Sense Organs

330	*Cerebral degenerations*
344.0-344.09	Quadriplegia and Quadriparesis
331.0-331.9	Reye's Syndrome
344.1	Paraplegia
348.0-348.9	Encephalopathy
357, 358	Neuropathy / Myasthenia Gravis

390-459 Diseases of the Circulatory System

410-410.9	Acute Myocardial Infarction
411-411.89	Acute and Subacute Ischemic Heart Disease
414-414.05	Coronary Atherosclerosis (ASHD)
415-415.19	Acute Pulmonary Heart Disease
416-416.9	Chronic Pulmonary Heart Disease
417.1	Aneurysm of Pulmonary Artery
421-421.9	Acute and Subacute Endocarditis
424-424.9	Valve Disorders
425-425.9	Cardiomyopathy
426-426.9	Conduction Disorders
427-427.9	Cardiac Dysrhythmias
428-428.9	Heart Failure
430, 431	Subarachnoid / Intracerebral Hemorrhage
434.9	Occlusion of Cerebral Arteries
436	Acute Cerebrovascular Accident (CVA)
440-441.9	Atherosclerosis / Aortic Aneurysm

460-519 Diseases of the Respiratory System

480-486	Pneumonia
490-496	Chronic Obstructive Pulmonary Disease (COPD), etc.
515	Postinflammatory Pulmonary Fibrosis
518-518.89	Pulmonary Collapse and/or Respiratory Failure

520-579 Diseases of the Digestive System

555-555.9	Regional Enteritis (Crohn's Disease)
560.0-560.9	Intestinal Obstruction
562.1	Diverticulitis of Colon
567-567.9	Peritonitis
569.0-569.9	Other Disorders of Intestine
570-571.9	Liver Diseases and Cirrhosis
572.8	Other Sequela of Chronic Liver Disease
573-573.9	Other Liver Disorders
577-577.9	Pancreas Diseases
578-578.9	Gastrointestinal Hemorrhage

580-629 Diseases of the Genitourinary System

584-584.9	Acute Renal Failure
585	Chronic Renal Failure
586	Renal Failure, Unspecified
588	Disorders resulting from impaired renal function
592	Calculus of Kidney & Uerter

630-677 Complications of Pregnancy, Childbirth

641.1	Placenta Previa
642.5-642.7	Eclampsia, pre-eclampsia
644.0-644.2	Premature Labor
648.0	Gestational Diabetes
651	Multiple Gestation
654.5	Cervical Incompetence

710-739 Diseases of the Musculoskeletal System and Connective Tissue

715.0-715.9	Osteoartrhosis
721.3	Lumbosacrel Spondylosis
722.0-722.9	Intervertebral Disc Disorders
730-730.9	Osteomyelitis and/or Periostitis
737.3	Kyphoscoliosis and scoliosis

740-759 Congenital Anomalies

747.2	Aortic Atresia / Stenosis
751.6	Biliary Atresia
759-759.9	Other and Unspecified Congenital Anomalies

760-779 Conditions Originating in the Perinatal Period

765-765.1	Prematurity
769	Respiratory Distress Syndrome
770.0-770.9	Other Respiratory Conditions of Newborn

780-799 Symptoms, Signs, and Ill-Defined Conditions

785-785.9	Symptoms Involving Cardiovascular System
786.5-786.59	Chest Pain

800-999 Injury and Poisoning

800-804.9	Fracture of Skull
805-805.9	Fracture of Vertebral Column
806-806.9	Fracture of Vertebral Column with Spinal Cord Injury
828-828.1	Multiple Fractures
853-854.1	Intracranial Injury
869-869.1	Internal Injury
887-887.7	Traumatic Amputation of Arm and Hand
897-897.7	Traumatic Amputation of Leg
949-949.5	Burns
952-952.9	Spinal Cord Injury
996-997.0	Complications peculiar to certain specified conditions
V23	Supervision of High Risk Pregnancy
V42 – V58.9	Transplants, etc

APPLICATION TO WESCO INSURANCE COMPANY
AND SCHEDULE OF EXCESS STOP-LOSS INSURANCE
FOR
AGGREGATE AND SPECIFIC EXCESS LOSS INSURANCE

POLICYHOLDER (hereinafter referred to as **You**, **Your**) **– MAIN MAILING ADDRESS**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Subsidiary or affiliated companies to be included (list legal names and addresses):

Name			Name		
Address			Address		
City	State	Zip Code	City	State	Zip Code

SIC/Industry Description: _____ State of Jurisdiction: _____

POLICY NUMBER: _____
(issued upon acceptance of this **Schedule of Excess Stop-Loss Insurance**)

Policy Period Effective Date: _____ Expiration Date: _____
(dates are as of 12:01 a.m. local time at **Your** main mailing address shown above)

ADMINISTRATOR

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

A. SPECIFIC EXCESS LOSS INSURANCE

Minimum Number of Full Time Employees: _____

1. Benefits Covered:
   ❑ Medical ❑ Prescription Drugs ❑ Dental ❑ Vision ❑ Other _____

2. **Benefit Period** shall consist of the following **Incurred** and **Paid** bases:
   Covered Services which are **Incurred** from _____* to _____*; and
   Eligible Services which are **Paid** from _____* to _____*
   (*dates are as of 12:01 a.m. local time at **Your** main mailing address shown above)

3. **Specific Attachment Point**: $_____ (minimum of $_____) per **Covered Person** for all occurrences.

4. **Specific Reimbursement Percentage** _____% (maximum 100%)

5. [Specific benefit limit $_____ ❑ **Policy Period** ❑ **Specific Lifetime Maximum Reimbursement]**

6. ❑ **Run-In Limit** / ❑ **Run-Out Limit**: $_____

7. Monthly Specific Premium Rate and **Covered Units**:

	Rate:	**Covered Units**:	
Single/Employee	$_____	Single/Employee	_____
Family/Dependent	$_____	Family/Dependent	_____
Composite (Single and Family)	$_____	Total	_____

B. AGGREGATE EXCESS LOSS INSURANCE

1. Benefits Covered:
   ❑ Medical ❑ Prescription Drugs ❑ Dental ❑ Vision ❑ Other _____

2. **Benefit Period** shall consist of the following **Incurred** and **Paid** claims bases:
   Covered Services which are **Incurred** from _____* to _____*; and
   Covered Services which are **Paid** from _____* to _____*
   (*dates are as of 12:01 a.m. local time at **Your** main mailing address shown above)

3. **Individual Claim Limit** accumulating toward the **Aggregate Excess Stop-Loss Insurance** $_____.

4. **Minimum Annual Aggregate Attachment Point**: $_____ or _____% of the first monthly aggregate attachment point x ____ months, whichever is greater.

5. **Aggregate Reimbursement Percentage:** _____%

6. [**Maximum Aggregate Reimbursement:** $_____]

7. ❑ **Run-In Limit** / ❑ **Run-Out Limit:** $_____

8. **Monthly Aggregate Factors** and **Covered Units**:

	Factors:	**Covered Units**:	
Single/Employee	$_____	Single/Employee	_____
Family/Dependent	$_____	Family/Dependent	_____
Composite (Single and Family)	$_____	Total	_____

C. OPTIONS

	Yes	No	
1. **Actively at Work** waived?	❑	❑	
2. **Retired Employees** and dependents covered?	❑	❑	If yes, limited to: $_____
3. Disabled Employees	❑	❑	If yes, limited to: $_____
4. COBRA, FMLA or other continuee	❑	❑	If yes, limited to: $_____

D. FRAUD NOTICE

Arkansas
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from

insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New Jersey
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New York
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Tennessee
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

E. CONDITIONS

As conditions precedent to the approval of this **Schedule**:

1. **You** shall furnish to **Us**, for our approval, a copy of the **Your** Employee Welfare Benefit **Plan** or **Your** PPO/HMO member booklet/certificate (herein referred to as Plan Document) describing the benefits provided by **You**. No **Policy** will be released or claim reimbursed until such time as an acceptable Plan Document is received and approved by us. In the event of a variance between the Plan Document received by us and the terms of the **Excess Stop-Loss Insurance** upon which such **Excess Stop-Loss Insurance** was based, **We** reserve the right to revise the premium rates, factors, terms and/or conditions. **We** may decline to release the **Policy** until such time as **You** provide written acceptance of the revisions, if any;

2. The dated **"**Disclosure Statement**"**, experience, census and other information provided by **You**, directly or through **Your TPA**, are primary data elements on which our proposal is based. In accepting the **Policy**, **You** represent that, to the best of **Your** knowledge and belief, such information is true;

3. The receipt by **Us** of any sum(s) referenced herein and the deposit of any check drawn in connection with this Schedule of Excess Stop-Loss Insurance shall not constitute an acceptance of liability by us. In the event we do not approve this Schedule of Excess Stop-Loss Insurance, **Our** sole obligation shall be to refund such sum(s) to **You**, and;

4. **You** understand and agree: (1) the **Excess Stop-Loss Insurance** applied for shall not take effect until such insurance has been approved by us and accepted as confirmed by delivery of the **Policy** to **You**, or to **Your TPA**; (2) the **Plan Document** attached and referred herein shall be the basis of the **Policy** issued by us and such **Plan Document** conforms with applicable State and Federal statutes; and (3) any reimbursement shall be determined in accordance with the **Plan Document** and the **Policy** that is the subject of this Schedule of Excess Stop-Loss Insurance.

F. FORMS AND RIDERS

G. NOTICE

Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

H. SIGNED ACCEPTANCE

Accepted on behalf of the Applicant: [Employer]__ _____

Signed By: _____

Printed Name: _____

Title: _____

Dated at [Anytown, Anystate]___ this [15th] day of [June], [2011].

Tax ID # _____

Witness:_____
Signature of Licensed Resident Agent

Licensed Resident Agent: [Robert Smith]___

Address: [123 Main Street]

City: [Anytown] State: [Anystate] Zip: [99999]

Social Security or Tax ID # [000-00-0000]

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Rate Information

Rate data applies to filing.

Filing Method: priopr approval
Rate Change Type: %
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Wesco Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:		Attachments
Approved-Closed 09/08/2011	rate manual cover	AH990004	Other	Previous State Filing Number: Percent Rate Change Request:		Cover page - Specific Stop Loss.pdf Cover page - Aggregate Stop Loss.pdf
Approved-Closed 09/08/2011	rate manual cover	AH990004	Other	Previous State Filing Number: Rate Action Other Explanation:	rate manual approved for Tillinghast (Towers Watson) and adopted by Wesco	

HealthMAPS®

2011

Specific Stop Loss Manual and Software

January 2011

TOWERS WATSON

HealthMAPS®

2011

Aggregate Stop Loss Manual and Software

January 2011

TOWERS WATSON

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/08/2011
Bypass Reason:	application attached to forms tab		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/08/2011
Comments:			
Attachment:			

FleschCertificationsigned.pdf

		Item Status:	Status Date:
Satisfied - Item:	authorization to file	Approved-Closed	09/08/2011
Comments:			
Attachment:			

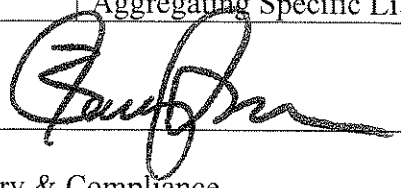
Filing authorization.pdf

WESCO INSURANCE COMPANY

FLESCH CERTIFICATION

I, Barry W. Moses an officer of Wesco Insurance Company, certify that the forms listed below satisfy the NAIC Model Bill standards of life and health insurance policy language simplification legislation.

Form Number	Form Title	Flesch Score
AH990004/ SL-DISCLOSURE	Stop Loss Policy with Disclosure Form	55.6
AH990006	Aggregate Excess Terminal Liability Rider	48.0
AH990008	Monthly Cumulative Accommodation Rider	51.2
AH990005	Advanced Funding Rider	50.8
WIC-AHSL-APP	Employer Application/Schedule	56.2
AH990009	Family Specific Deductible Rider	57.2
AH990010	Specific Loss Terminal Liability Rider	46.8
AH990007	Aggregating Specific Liability Rider	42.5

Signature of Officer: 

Title: VP, Regulatory & Compliance

Date: 8/30/11

Wesco Insurance Company

An AmTrust Financial Company

August 18, 2011

To: Various Departments of Insurance

Re: Authorization to Represent Wesco Insurance Company

Wesco Insurance Company
NAIC # 25011
FEIN # 85-0165753
Letter of Authorization
Filing of Forms, Rates & Rules

Dear Sir or Madam:

This letter, or a copy thereof, will authorize the consulting firm of Coulter & Associates of Cranbury, New Jersey, to represent Wesco Insurance Company before your Insurance Department solely with respect to matters concerning filing for approval of Wesco Insurance Company's Stop Loss Program and associated premium rates. The TOI for these filings are H12 Health – Excess/Stop Loss and the Sub-Type is H12.001 Accident & Sickness (in Connecticut 17.1 Other Liability-Occ Onl/ 17.1004 Contractual Liability).

This authorization will remain in effect until revoked in writing by Wesco Insurance Company.

Please direct any correspondence in relation to this filing to Coulter & Associates, 379 Princeton-Hightstown Road, Cranbury, NJ 08512, (609) 443-7540, or by e-mail to susan@coulter-and-assocates.com.

The contact person with Wesco Insurance Company is Karen Owsiany, 500 Enterprise Dr., Suite 3C, Rocky Hill, CT 06067. I can be reached by phone at (860) 571-2160 or by e-mail at karen.owsiany@amtrustgroup.com.

Sincerely,

Karen Owsiany

59 Maiden Lane • 6th Floor • New York, NY 10038 • **212.220.7120** • Fax: 212.220.7130
www.amtrustgroup.com

SERFF Tracking Number:	*UNKP-127390241*	*State:*	*Arkansas*
Filing Company:	*Wesco Insurance Company*	*State Tracking Number:*	*49692*
Company Tracking Number:	*AH990004*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.001 Accident & Sickness*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss Filing/AH990004*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/29/2011	Form	Application and Schedule of Excess Stop-Loss Insurance	09/08/2011	WIC-AHSL-APP 0811.pdf (Superceded)

APPLICATION TO WESCO INSURANCE COMPANY
AND SCHEDULE OF EXCESS STOP-LOSS INSURANCE
FOR
AGGREGATE AND SPECIFIC EXCESS LOSS INSURANCE POLICYHOLDER (hereinafter referred to as **You**, **Your**) **– MAIN MAILING ADDRESS**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Subsidiary or affiliated companies to be included (list legal names and addresses):

Name			Name		
Address			Address		
City	State	Zip Code	City	State	Zip Code

SIC/Industry Description: _____ State of Jurisdiction: _____

POLICY NUMBER: _____
(issued upon acceptance of this **Schedule of Excess Stop-Loss Insurance**)

Policy Period Effective Date: _____ Expiration Date: _____
(dates are as of 12:01 a.m. local time at **Your** main mailing address shown above)

ADMINISTRATOR

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

A. SPECIFIC EXCESS LOSS INSURANCE

Minimum Number of Full Time Employees: _____

1. Benefits Covered:
   ❑ Medical ❑ Prescription Drugs ❑ Dental ❑ Vision ❑ Other _____

2. **Benefit Period** shall consist of the following **Incurred** and **Paid** bases:
   Covered Services which are **Incurred** from _____* to _____*; and
   Eligible Services which are **Paid** from _____* to _____*
   (*dates are as of 12:01 a.m. local time at **Your** main mailing address shown above)

3. **Specific Attachment Point**: $_____ (minimum of $_____) per **Covered Person** for all occurrences.

4. **Specific Reimbursement Percentage** _____% (maximum 100%)

5. [Specific benefit limit $_____ ❑ **Policy Period** ❑ **Specific Lifetime Maximum Reimbursement]**

6. ❑ **Run-In Limit** / ❑ **Run-Out Limit**: $_____

7. Monthly Specific Premium Rate and **Covered Units**:

	Rate:	**Covered Units**:	
Single/Employee	$_____	Single/Employee	_____
Family/Dependent	$_____	Family/Dependent	_____
Composite (Single and Family)	$_____	Total	_____

B. AGGREGATE EXCESS LOSS INSURANCE

1. Benefits Covered:
   ❑ Medical ❑ Prescription Drugs ❑ Dental ❑ Vision ❑ Other _____

2. **Benefit Period** shall consist of the following **Incurred** and **Paid** claims bases:
   Covered Services which are **Incurred** from _____* to _____*; and
   Covered Services which are **Paid** from _____* to _____*
   (*dates are as of 12:01 a.m. local time at **Your** main mailing address shown above)

3. **Individual Claim Limit** accumulating toward the **Aggregate Excess Stop-Loss Insurance** $_____.

4. **Minimum Annual Aggregate Attachment Point**: $_____ or _____% of the first monthly aggregate attachment point x ____ months, whichever is greater.

5. **Aggregate Reimbursement Percentage:** _____%

6. [**Maximum Aggregate Reimbursement:** $_____]

7. ❑ **Run-In Limit** / ❑ **Run-Out Limit:** $_____

8. **Monthly Aggregate Factors** and **Covered Units**:

	Factors:	**Covered Units**:	
Single/Employee	$_____	Single/Employee	_____
Family/Dependent	$_____	Family/Dependent	_____
Composite (Single and Family)	$_____	Total	_____

C. OPTIONS

	Yes	No	
1. **Actively at Work** waived?	❑	❑	
2. **Retired Employees** and dependents covered?	❑	❑	If yes, limited to: $_____
3. Disabled Employees	❑	❑	If yes, limited to: $_____
4. COBRA, FMLA or other continuee	❑	❑	If yes, limited to: $_____

D. FRAUD NOTICE

Arkansas
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New Jersey
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New York
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Tennessee
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

E. CONDITIONS

As conditions precedent to the approval of this **Schedule**:

1. **You** shall furnish to **Us**, for our approval, a copy of the **Your** Employee Welfare Benefit **Plan** or **Your** PPO/HMO member booklet/certificate (herein referred to as Plan Document) describing the benefits provided by **You**. No **Policy** will be released or claim reimbursed until such time as an acceptable Plan Document is received and approved by us. In the event of a variance between the Plan Document received by us and the terms of the **Excess Stop-Loss Insurance** upon which such **Excess Stop-Loss Insurance** was based, **We** reserve the right to revise the premium rates, factors, terms and/or conditions. **We** may decline to release the **Policy** until such time as **You** provide written acceptance of the revisions, if any;

2. The dated **"**Disclosure Statement**"**, experience, census and other information provided by **You**, directly or through **Your TPA**, are primary data elements on which our proposal is based. In accepting the **Policy**, **You** represent that, to the best of **Your** knowledge and belief, such information is true;

3. The receipt by **Us** of any sum(s) referenced herein and the deposit of any check drawn in connection with this Schedule of Excess Stop-Loss Insurance shall not constitute an acceptance of liability by us. In the event we do not approve this Schedule of Excess Stop-Loss Insurance, **Our** sole obligation shall be to refund such sum(s) to **You**, and;

4. **You** understand and agree: (1) the **Excess Stop-Loss Insurance** applied for shall not take effect until such insurance has been approved by us and accepted as confirmed by delivery of the **Policy** to **You**, or to **Your TPA**; (2) the **Plan Document** attached and referred herein shall be the basis of the **Policy** issued by us and such **Plan Document** conforms with applicable State and Federal statutes; and (3) any reimbursement shall be determined in accordance with the **Plan Document** and the **Policy** that is the subject of this Schedule of Excess Stop-Loss Insurance.

F. FORMS AND RIDERS

G. SIGNED ACCEPTANCE

Accepted on behalf of the Applicant: [Employer]__ _____

Signed By: _____

Printed Name: _____

Title: _____

Dated at [Anytown, Anystate]___ this [15th] day of [June], [2011].

Tax ID # _____

Witness:_____
Signature of Licensed Resident Agent

Licensed Resident Agent: [Robert Smith]___

Address: [123 Main Street]

City: [Anytown] State: [Anystate] Zip: [99999]

Social Security or Tax ID # [000-00-0000]